STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344003	A. BUILDING _____ B. WING _____	C 03/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HOSPITAL	201 STEVENS MILL ROAD GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 006	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. This CONDITION is not met as evidenced by: An unannounced visit was made to the hospital on 3-7-06 and 3-8-06 to investigate a patient death in the hospital's U-2/2West unit. Based on staff interview, medical record review, hospital documents and review of hospital policies and procedures, the hospital's governing body failed to ensure that: A) A patient in restraints was monitored in accordance with hospital policy. B) Conditions of Participation were met. C) nursing services were furnished or supervised by a registered nurse, and D) a registered nurse supervised and evaluated the nursing care for each patient. Immediate Jeopardy was cited due to the lack of patient safety, as: A) patients were not monitored by staff in accordance with hospital policy. The cumulative effect of these systemic problems resulted in the hospital's inability to ensure patients received care in a safe environment. A) Cross refer: Tag A0016 Governing Body CFR 482.12(c). The governing body failed to ensure a	A 006		3/20/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 006	Continued From page 1 patient in restraints was assessed, monitored, and reevaluated as required by the hospital's policies and procedures.	A 006		
A 016	482.12(c) CARE OF PATIENT In accordance with hospital policy, the governing body must ensure that specific patient care requirements are met. This STANDARD is not met as evidenced by: Based on staff interview, medical record review, hospital documents, and review of hospital policies and procedures, the hospital's governing body failed to ensure hospital policies and procedures were implemented and specific patient care needs were met in the hospital's U-2/2West. A) Cross refer: Tag A-079 Patient Rights, CFR 482.13(f)(3)(ii). Hospital staff failed to obtain an MD/DO or LIP order for restraint. B) Cross refer: Tag A-089 Patient Rights, CFR 482.13(f)(3)(vi). Hospital staff failed to end restraints at the earliest possible time. C) Cross refer: Tag A-092 Patient Rights, CFR 482.13(f)(5). Hospital staff failed to assess, monitor, and reevaluate the condition of a patient who was in restraints. D) Cross refer: Tag A-204 Staffing and Delivery of Care, CFR 482.23(b)(3). Hospital staff failed to supervise and evaluate the nursing care for each patient.	A 016		3/20/06
A 038	482.13 PATIENTS' RIGHTS	A 038		3/31/06

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A 038	Continued From page 2 A hospital must protect and promote the rights of each patient. This CONDITION is not met as evidenced by: Based on medical record review, policies and procedures review, hospital document review and staff interviews, the hospital failed to protect and promote each patient's right to safety during a restraint, and be provided with staff monitoring to prevent harm. Specifically, staff did not provide monitoring on U-2/2 West in accordance with hospital policy and procedure. Immediate Jeopardy was cited due to lack of patient safety. A) Cross refer: Tag A-0079 Patient Rights CFR 482.13(f)(3)(ii) The hospital failed to protect and promote 1 of 1 patient's rights on U-2/2 West by failing to ensure that an MD/DO or LIP ordered restraints prior to the application of the restraint. B) Cross refer: Tag A-0089 Patient Rights CFR 482.13(f)(3)(vi) The hospital failed to protect and promote 1 of 1 patient's rights on U-2/2 West by failing to end restraints at the earliest possible time. C) Cross refer Tag A-0092 Patient Rights CFR 482.13(f)(5) The hospital failed to protect and promote 1 of 1 patient's rights on U-2/2 West by failing to assess, monitor, and reevaluate the condition of the patient who was in restraints. D) Cross refer Tag-95 Patient Rights CFR 482.13(f)(7)	A 038		

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A 038	Continued From page 3 The hospital failed to protect patient rights in the hospital by failing to report to CMS, a death of a patient that occurred while that patient was restrained.	A 038		
A 079	482.13(f)(3)(ii) PHYSICIAN ORDER FOR SEC & RESTRAINT The use of a restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner permitted by the State and hospital to order seclusion or restraint. The following requirements will be superseded by existing State laws that are more restrictive. This STANDARD is not met as evidenced by: Based on hospital policy and procedure review, hospital document and medical record review, nursing staff did not procure a physician order for each episode of restraints for 1 of 1 patient sampled (patient #1) who was restrained for behavior management. Findings include: Medical record review conducted on 3-7-06 revealed patient #1, a 35 year-old female who was admitted to U-2/2 West on 2-17-06 at 1:00am with a diagnosis of Paranoid Schizophrenia. Further review of the medical record revealed a nursing progress note, dated 2-17-06 at 9:45am, which revealed patient #1 was transported to a medical hospital via EMS where she was pronounced dead at 9:31am. Further review of the medical record revealed a	A 079		4/10/06

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A 079	Continued From page 4 physician progress note dated 2-17-06 at 215pm, which revealed "Pt was placed back in 4 pt restraints at 7:30 AM without incident, was being watched. No physical distress noted till 845 AM when pt was found unresponsive and no V.S. (vital signs) code blue called & CPR started." Hospital policy and procedure review conducted on 3-7-06 revealed, "Isolation Time Out/ Seclusion, Restraint/Psychiatric Care." Under, "E. Initiating Isolation Time Out, Seclusion or Restraint... 1. Nursing Staff Interventions - When a properly trained nursing staff member is presented with a situation requiring emergency use of ITO (isolation time out), seclusion, or restraint, and it is not possible to involve the patient's physician or registered nurse, he/she may initiate ITO, seclusion, or restraint and use it for up to 15 minutes. ... 2. Registered Nurse Interventions. The Registered Nurse who has been trained will:... a. Conduct an assessment to begin as soon as possible but at least within 15 minutes of the initiation of ITO, seclusion, or restraint to include: ... b. Contact the treating physician immediately after the assessment to (if the treating physician is not available, contact the covering physician immediately): 1) Discuss the results of the RN assessment. 2) Obtain a written or verbal order as soon as possible for use of ITO, seclusion or restraint but least within 1 hour of initiation. If an order is not obtained within an hour from initiation, the patient must be released. c. Document on Form - Restrictive Procedures Progress Note 1) A detailed description of the behavior exhibited	A 079		

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A 079	Continued From page 5	A 079		

by the patient that led to him/her being placed in ITO, seclusion or restraint.
2) Assessment of the patient's physical and emotional status and level of agitation and aggression, with a description of the specific behaviors exhibited by the patient.
3) Inadequacy of less restrictive interventions.
4) Method used to transport the patient to ITO, seclusion or restraint and the patient's response to the transport and the names of staff members transporting the patient.
5) Pertinent medical and abuse history relevant to use of ITO, seclusion or restraints.
6) Explanations given to the patient regarding why in restrictive interventions, behaviors required for release, observation by staff and assurance of safety and his/her response.
7) RN-authorized continued use of ITO, seclusion or restraint.
8) Name of physician contacted."

Medical record review conducted on 3-7-06 revealed a progress note written by staff #1(RN) dated 2-17-06 at (time illegible) which read, "Pt (patient #1) very out of control & out of restraints. Pt refused po meds & was given Haldol 10 mg, Ativan 2 mg, Benadryl 50 mg IM at 735 A. Placed back in restraints @ 740 A. VS P-74 R - 18 BP 138/76 @ 740 A. HCT (health care technician) in attendance."

Further review of the medical record revealed the document "Intramuscular Injections (IM) of Psychotropic Mediations for Behavioral Emergencies" signed by the physician on 2-17-06 at 7:45am which read, "PHYSICIAN 1. Target Behavior (Need for medication) Combative, got out of restraints. hit & spit on several techs & nurses."

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A 079	Continued From page 6 Review of the Administrative Investigation Report on 03/07/2006 revealed staff #1's (RN)statement written in relation to the incident on 02/17/2006. "Arrived 7:00 a.m., went directly to 2W arriving on ward at 7:10 a.m. Patient (patient #1) in restraints - (staff #5 HCT) assigned to sit with her. Sitting outside the room-watching and keeping an eye on her as supposed to. I wasn't involved until a unit wide call for male help - never heard the call - sitting at desk trying to get together. Don't know if beeper went off or overhead call. ... Stepped outside room (office) saw all men - penned to the floor, outside restraint room. ... Already on floor - was on her stomach - that concerns me, but very combative and that was the best they could do. ... She was back in restraints at time he got vital signs. She had been very loud and mouthy, but when put back in restraints was different. Appeared limp. They told me she was like this would play possum, come back and hit you in face." Further review of the Administrative Investigation Report revealed staff #2's (RN) statement. "... At 7:25 - 7:30 a.m. preparing meds for another patient - about 5 minutes later told to give her Thorazine 300 mg, po because she (patient #1) had gotten out of restraints." Further review of the Administrative Investigation Report revealed staff #5's (HCT) statement. "... 7:15 a.m. she (patient #1) was singing and calm, looked up and she had both her arms out - started punching hit her hand - tried to get her fee(t) out - ... closed door to keep her in the room - pulled door out of her hand - ..." Hospital document entitled "A Framework for a	A 079		

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A 079	Continued From page 7 Root Cause Analysis and Action Plan In Response to a Sentinel Event" reviewed on 3-7-06 revealed, "Between 7:15 a.m. - 7:30 a.m., the patient got out of restraints and left the restraint room, reaching the area outside the 2 West restraint room. Staff members responded, an NCI hold was used and the patient was pinned on the floor for 10 minutes in front of the restraint room. ... Between 7:35 a.m. - 7:40 a.m., she was returned to the restraint room, her clothes were changed due to her urinating, and she was restrained again in 4 point restraints. Further review of the document revealed the question, "What human factors were relevant to the outcome?" The analysis states, "Documentation of the restrictive procedure was not done according to hospital policy. The patient got out of restraints and left the room, necessitating another NCI hold and reapplication of restraints. This would have required a new MD order which was not done. There was no documentation by nursing staff regarding this occurrence." Review of patient #1's medical record revealed no evidence a physician's order was obtained for the NCI hold used after patient #1 got out of restraints. Interview with administrative staff on 3-8-06 confirmed a physician's order was not obtained for the NCI hold used after patient #1 got out of restraints.	A 079		
A 089	482.13(f)(3)(vi) ENDING SEC & RESTRAINT ASAP The use of a restraint or seclusion must be ended at the earliest possible time.	A 089		3/31/06

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A 089	Continued From page 8	A 089		

This STANDARD is not met as evidenced by:
Based on medical record review, review of hospital documents, staff interviews, and review of policy and procedure, staff failed to ensure a physical restraint ended at the earliest possible time for 1 of 1 sampled patient (patient #1) who was restrained for behavior management.

Findings include:

Medical record review conducted on 3-7-06 revealed patient #1, a 35-year-old female who was admitted to U-2/2 West on 2-17-06 at 1:00am with a diagnosis of Paranoid Schizophrenia. Further review of the medical record revealed a nursing progress note, dated 2-17-06 at 9:45am, which revealed patient #1 was transported to a medical hospital via EMS, where she was pronounced dead at 9:31am.

On 3-7-06 the hospital's policy entitled "Isolation Time Out/Seclusion, Restraint/Psychiatric Care" was reviewed. Under the section "I. Releasing the Patient and Integrating Him/Her Back into the Milieu", the policy stated "1. Remove the patient from ITO (isolation time out), seclusion or restraint as soon as possible when he/she demonstrates the release criteria specified in the physician's order. In no case shall the patient remain in seclusion, ITO or restraint longer than 30 minutes after meeting the release criteria unless it is during regularly scheduled sleeping hours, and the patient requests to remain until morning."

Further review of the policy revealed section "G. During Isolation Time Out, Seclusion, or

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A 089	Continued From page 9	A 089		

Restraint", which stated "2. Registered Nurse Interventions: b. Evaluate at least every hour to determine the continued need for ITO, seclusion or restraint and document assessments on Restrictive Procedures Progress Note Form".

Review of patient #1's medical record revealed a nursing progress note, dated 2-17-06 (time illegible), which indicated patient #1 had been "loud, intrusive, cheering, chanting, cursing, threatening - refusing to comply (with) ward". The progress note further revealed staff was "unable to effectively redirect" patient #1 and medications, Haldol 7.5mg and Benadryl 50mg IM (intramuscular), were given per physician's order at 5:10am. According to the nursing note patient #1's behavior "continued to escalate" and she "attempted to choke staff member". The note revealed patient #1 was "Placed in NCI hold and then 4 pt (point) restraints at 5:45am. Restraints applied correctly".

Further review of the medical record revealed the Restrictive Intervention for Behavior Record, dated 2-17-06, which indicated patient #1 was placed in 4-point restraints from 5:45am - 8:50am, at which time a code blue was called. The document revealed the following information regarding patient #1's restraint episode on 2-17-06:

5:45am - "Attempted to choke staff member in office doorway. Loud threatening and assaultive".
6:00am - "Shaking bed. Pulling at restraints. Refuses to speak to staff".
6:15am - "Pulling restraints threatening staff, yelling, cursing...".
6:30am - "Setting up in bed, cursing staff, yelling...".

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A 089	Continued From page 10	A 089		

6:45am - "Loud, cursing, threatening, unable to contract for safety".
7:00am - "Continue restraints".
7:00am - "loud, cursing, threatening staff...".
7:15am - "loud, yelling...".
7:30am - "loud, yelling, cursing @ staff. Shaking bed".
7:45am - "Pt. Laying in bed, Quiet @ this time. V/S (vital signs) being taking by nurse".
8:00am - "Pt has been Quiet, Resting in bed".
8:15am - "Pt. Quiet. Just laying in bed".
8:30am - "Pt. still lying in bed, no move".
8:50am - "Code Blue call, Med. Emergency".

The Restrictive Intervention for Behavior Record, dated 2-17-06, revealed no evidence staff attempted to release patient #1 from 4-point restraints after 4 consecutive 15-minute checks (7:45am, 8:00am, 8:15am, 8:30am) where it was documented patient #1 was "quiet" and "lying in bed".

Medical record review revealed no evidence a registered nurse evaluated patient #1 every hour, as outlined in the "Isolation Time Out/Seclusion, Restraint/Psychiatric Care" policy, to determine the continued need for 4-point restraints.

On 3-7-06 the hospital document, "A Framework for a Root Cause Analysis and Action Plan In Response to a Sentinel Event" was reviewed. The document stated "The patient (patient #1) was noted to be lying quietly in bed at 7:45a.m., 8:00a.m., 8:15a.m., and 8:30a.m. An assessment was not done and the patient was not released from restraints as required by policy after two consecutive checks of meeting the release criteria".

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A 089	Continued From page 11 On 3-8-06 interviews were conducted with staff who assisted with patient #1 on 2-17-06. Staff #1 was a registered nurse (RN) who floated to U2/2West day shift on 2-17-06. Staff #1 reported by the time she arrived to the ward (2 West) patient #1 was on the floor outside of the restraint room with approximately 15 people surrounding her. According to staff #1, patient #1 received injections and staff got patient #1 back in bed (restraints) after a few minutes. Staff #1 reported staff #4 (charge nurse) got injured and went to Employee Health. Staff #1 reported other staff (healthcare technicians) also left the ward. Staff #1 stated "Everybody left except me and (name of staff #16, who was providing constant observation for patient #1). Interview revealed no evidence staff #1 attempted to release patient #1 from 4-point restraints after it was noted patient #1 was resting for 4 consecutive 15-minute checks. Staff #16, a healthcare technician (HCT), provided 1:1 monitoring of patient #1 on 2-17-06 from 7:45am until the code blue was called at 8:50am. Interview revealed no evidence staff #16 attempted to release patient #1 from 4-point restraints after 4 consecutive 15-minute checks (7:45am, 8:00am, 8:15am, 8:30am) where he documented patient #1 was "quiet" and "lying in bed". On 3-8-06 staff #16's statement was reviewed. The statement revealed "...From time I picked up clipboard she was quiet, said to myself - 2 checks and quiet-could take her out (of restraints)...If up to me, I'd have taken her out (of restraints)". The statement revealed no evidence staff #16 made an attempt to release patient #16 from 4-point restraints	A 089		

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A 089	Continued From page 12 Interview with administrative staff on 3-8-06 confirmed staff made no attempts to release patient #1 from restraints at the earliest time possible. Administrative staff also confirmed a registered nurse did not evaluate patient #1 hourly, according to hospital policy, to determine the need for continued use of 4-point restraints.	A 089		
A 092	482.13(f)(5) CONTINUOUS ASSESSMENT The condition of the patient who is in a restraint or in seclusion must continually be assessed, monitored, and reevaluated. This STANDARD is not met as evidenced by: Based on medical record review, review of hospital documents, staff interviews, and review of policies and procedures, the hospital failed to continuously assess, monitor, and reevaluate a patient in restraints for 1 of 1 patient sampled (patient #1) who was restrained for behavior management. Findings include: Medical record review conducted on 3-7-06 revealed patient #1, a 35-year-old female who was admitted to U-2/2 West on 2-17-06 at 1:00am with a diagnosis of Paranoid Schizophrenia. Further review of the medical record revealed a nursing progress note, dated 2-17-06 at 9:45am, which revealed patient #1 was transported to a medical hospital via EMS, where she was pronounced dead at 9:31am. Further review of patient #1's medical record revealed a nursing progress note, dated 2-17-06 at 3:00pm (late entry for 9:00am), which stated "Entered room @ approx (approximately) 8:45	A 092		3/22/06

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(after) HCT (healthcare technician) unable to obtain VS. Pt. unresponsive. Color good - no cyanosis. Unable to obtain BP or apical pulse. (Name of Nurse Manager and Nurse Practitioner) notified immediately. Code blue called @8:50A".

Further review of patient #1's medical record revealed a late entry progress note from the nurse practitioner, dated 2-17-06 at 1510 (3:10pm). The note stated "Asked to evaluate pt in restraint room @ approx 0850 due to having difficulty obtaining pt's BP - After attempting to ck (check) BP x 1 (which was unobtainable) pt was found to be absent of apical pulse and resp. Code Blue Called and CPR initiated...CPR in progress while transported to (name of medical hospital)".

On 3-7-06 the hospital document, "A Framework for a Root Cause Analysis and Action Plan In Response to a Sentinel Event" was reviewed. The document revealed a Code Blue was called on 2-17-06 at 8:50am after staff discovered patient #1 was "absent of a pulse, blood pressure, and respirations". The document indicated patient #1 was in 4-point restraints when the Code Blue was called. Further review of the document revealed patient #1's only identified medical problem was obesity and "There was no evidence of medical instability at the time of admission to Cherry Hospital".

On 3-7-06 the hospital's policy entitled "Isolation Time Out/Seclusion, Restraint/Psychiatric Care" was reviewed. The policy stated "G. During Isolation Time Out, Seclusion, or Restraint 1. Nursing Staff Interventions a. Monitor the patient through constant in-person observation and document on the Restrictive Interventions

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Progress Note Form".

Additionally, under "G. During Isolation Time Out, Seclusion, or Restraint", the policy revealed "1. Nursing Staff Interventions a. 1) Monitor for the following every 15 minutes:
a) Signs of injury.
b) Nutrition/hydration.
c) Vital signs and circulation.
d) Hygiene and elimination
e) Physical status (e.g., breathing) and psychological status (e.g., increased agitation) and comfort.
f) Meeting the criteria for release.
g) If the patient in restraints struggles against the restraints or is hyperactive, observe the patient for early signs of exhaustion (e.g. change in level of consciousness, increased pulse or breathing, sweating, etc."

Further review of the policy, "Isolation Time Out/Seclusion, Restraint/Psychiatric Care", revealed "G. During Isolation Time Out, Seclusion, or Restraint 2. Registered Nurse Interventions: b. Evaluate at least every hour to determine the continued need for ITO (isolation time out), seclusion, or restraint and document assessments on Restrictive Procedures Progress Note Form".

Review of patient #1's medical record revealed a nursing progress note, dated 2-17-06 (time illegible), which indicated patient #1 had been "loud, intrusive, cheering, chanting, cursing, threatening - refusing to comply (with) ward". The progress note further revealed staff was "unable to effectively redirect" patient #1 and medications, Haldol 7.5mg and Benadryl 50mg IM (intramuscular), were given per physician's order

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at 5:10am. According to the nursing note patient #1's behavior "continued to escalate" and she "attempted to choke staff member". The note revealed patient #1 was "Placed in NCI hold and then 4 pt (point) restraints at 5:45am. Restraints applied correctly".

Another nursing progress note, dated 2-17-06 (time illegible), stated patient #1 was "Very out of control and out of restraint. Pt (patient) refused po (oral) meds (medications) and was given Haldol 10mg, Ativan 2mg, and Benadryl 50mg IM @ 7:35A (am). Placed back in restraints @ 7:40A. VS (vital signs) P(pulse) - 74, R(respirations) - 18, BP (Blood Pressure) - 138/76 @ 7:40A". There was no documentation in the progress note regarding how and when patient #1 got out of restraints.

Further review of the medical record revealed the document "Intramuscular Injections (IM) of Psychotropic Medications for Behavioral Emergencies", dated 2-17-06. The physician section, signed and dated by the physician on 2-17-06 at 7:45am, revealed "Combative, Got out of restraints, hit and spit on several techs (healthcare technicians) and nurses". The document revealed no evidence regarding how and when patient #1 got out of restraints.

Further review of the medical record revealed the Restrictive Intervention for Behavior Record, dated 2-17-06, which indicated patient #1 was placed in 4-point restraints from 5:45am - 8:50am, at which time a
code blue was called. The document revealed the following information regarding patient #1's restraint episode on 2-17-06:

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5:45am - "Attempted to choke staff member in office doorway. Loud threatening and assaultive".
6:00am - "Shaking bed. Pulling at restraints. Refuses to speak to staff".
6:15am - "Pulling restraints threatening staff, yelling, cursing...".
6:30am - "Setting up in bed, cursing staff, yelling...".
6:45am - "Loud, cursing, threatening, unable to contract for safety".
7:00am - "Continue restraints".
7:00am - "loud, cursing, threatening staff...".
7:15am - "loud, yelling...".
7:30am - "loud, yelling, cursing @ staff. Shaking bed".
7:45am - "Pt. Laying in bed, Quiet @ this time. V/S (vital signs) being taking by nurse".
8:00am - "Pt has been Quiet, Resting in bed".
8:15am - "Pt. Quiet. Just laying in bed".
8:30am - "Pt. still lying in bed, no move".
8:50am - "Code Blue call, Med. Emergency".

The Restrictive Intervention for Behavior Record revealed no documentation that patient #1 had gotten out of restraints at any point from 5:45am - 8:50am.

On the Restrictive Intervention for Behavior Record, dated 2-17-06, staff documented patient #1 refused food/fluid at 6:45am, 7:45am, and 8:15am. According to the document, patient #1 refused toileting at 7:15am, 7:45am, and 8:15am. Additionally staff documented "N/A" (not applicable) for ROM (range of motion) at 6:15am, 6:30am, 7:00am, 7:15am, and 7:30am. There was no evidence on the Restrictive Intervention for Behavior Record that staff monitored the required components of patient #1's condition every 15 minutes as outlined in the hospital's

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policy "Isolation Time Out/Seclusion, Restraint/Psychiatric Care" (signs of injury, nutrition/hydration, vital signs and circulation, hygiene and elimination, physical and psychological status, meeting the criteria for release, and early signs of exhaustion).

According to patient #1's medical record, the last set of documented vital signs was at 7:40am (nursing progress note, dated 2-17-06 - time illegible), which was 1 hour and 10 minutes before the Code Blue was called.

Additionally, review of patient #1's medical record revealed no evidence nursing staff evaluated patient #1 at least hourly as outlined in the hospital's policy "Isolation Time Out/Seclusion, Restraint/Psychiatric Care".

Review of the hospital document, "A Framework for a Root Cause Analysis and Action Plan In Response to a Sentinel Event" revealed "Between 7:15a.m.-7:30a.m., the patient (patient #1) got out of restraints and left the restraint room, reaching the area outside the 2 West restraint room. Staff members responded...". The document further revealed there was no documentation in the medical record regarding how patient #1 was able to get out of restraints. The document stated "Policy requires 1:1 monitoring by staff when a patient is in restraints. The patient (patient #1) was able to get out of restraints and leave the restraint room before staff intervened".

Further review of "A Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event" revealed "The last verifiable documentation in the medical record in which it is known that the patient (patient #1) definitely had

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vital signs was 7:40 a.m. on 2-17-06". According to the document, no further attempts were made to obtain patient #1's vital signs until approximately 8:35am.

On 3-8-06 statements were reviewed from staff who assisted with patient #1 on 2-17-06.

According to staff #1's statement (a registered nurse), she arrived to the ward (2West) on 2-17-06 at 7:10am. The statement revealed staff #1 "Looked up and saw clock - hadn't gotten vital signs. Got equipment and took to him (staff #16, a healthcare technician) at 8:35a.m....He (staff #16) couldn't get vital signs, came and got me...". The statement revealed no evidence patient #1 was monitored every 15 minutes in accordance with the hospital policy "Isolation Time Out/Seclusion, Restraint/Psychiatric Care"

On 3-8-06 a telephone interview was conducted with staff #1, who reported on 2-17-06 she worked as a float nurse on U2/2West. Staff #1 reported by the time she arrived, patient #1 had gotten out of restraints and was on the floor outside the restraint room. Staff #1 reported she did not know how patient #1 got out of restraints.

On 3-8-06 staff #5's statement was reviewed. Staff #5 was a healthcare technician (HCT), who provided 1:1 monitoring of patient #1 on 2-17-06 from 7:00am - 7:30am. The statement revealed "(Name of physician and staff) went into room to talk to her (patient #1) to get blood and had (staff #16) hold her arm - was fussing and cursing (took from both arms). At 7:15a.m. she was singing and calm, looked up and she had both arms out -started punching hit her hand - tried to get her feet out...". The statement revealed no other

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A 092	Continued From page 19 evidence of how patient #1 was able to get out of restraints while being monitored 1:1. On 3-8-06 interview with administrative staff confirmed there was no documentation in the medical record regarding how patient #1 got out of restraints. Additionally, interview confirmed staff did not monitor patient #1 every 15 minutes as outlined in the hospital's policy. Administrative staff confirmed a registered nurse did not monitor patient #1 hourly to determine the continued need for restraints.	A 092		
A 095	482.13(f)(7) DEATH REPORTING The hospital must report to CMS any death that occurs while a patient is restrained or in seclusion, or where it is reasonable to assume that a patient's death is a result of restraint or seclusion. This STANDARD is not met as evidenced by: Based on hospital policy and procedure review and staff interview, the hospital failed to report to the Centers for Medicare & Medicaid Services (CMS) a death that occurred while a patient was restrained, within the required time frame, for 1 of 1 sampled patient (patient #1). Findings include: Hospital policy and procedure review conducted on 3-7-06 revealed, "Isolation Time Out/Seclusion, Restraint/Psychiatric Care." The policy states, "(The Hospital), in accordance with federal regulations, reports to the Center for Medicare and Medicaid Services (CMS) any death that occurs while a patient is in seclusion or restraint or when it is reasonable to assume that a patient's death is a result of seclusion or restraint.	A 095		3/22/06

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A 095	Continued From page 20 In addition, reporting shall be made to appropriate state agencies such as DFS in accordance with specific guideline requirements governing patient deaths. Further review of the policy and procedure revealed. "3. The Hospital Director's office shall notify the DHHS/MH, the Division of Facility Services, Joint Commission and Center for Medicare & Medicaid Services of any deaths that occur while the patient is in isolation time out, seclusion, or restraint or where it is reasonable to assume that the patient's death is a result of ITO, seclusion, or restraint. Staff interview conducted on 3-7-06 at 2:00pm revealed, the hospital did not report the death that occurred on 2-17-066 while a patient was in restraints to the Centers for Medicare and Medicaid Services (CMS).	A 095		
A 199	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on medical record review, hospital document review and staff interviews the hospital unit U-2/2 West failed to have effective systems in place to assure the safety of patients and to ensure that patient needs were met; specifically, nursing staff did not monitor 1 of 1 patients in restraints in accordance with hospital policy. Immediate Jeopardy was cited due to the lack of	A 199		3/22/06

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A 199	Continued From page 21 patient safety. Cross refer: Tag A-0204 Nursing Services CFR 482.23(b)(3). The registered nurse failed to supervise and monitor 1 of 1 patients, in restraints, in accordance with hospital policies and procedures.	A 199		
A 204	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: 1. Based on medical record review, review of hospital documents, staff interviews, and review of hospital policy and procedure, nursing staff failed to supervise the care of a patient for 1 of 1 sampled patients (patient #1) restrained for behavioral management. Specifically, nursing staff failed to ensure documentation of patient monitoring every 15 minutes in accordance with hospital policy. Findings include: Medical record review conducted on 3-7-06 revealed patient #1, a 35-year-old female who was admitted to U-2/2 West on 2-17-06 at 1:00am with a diagnosis of Paranoid Schizophrenia. Further review of the medical record revealed a nursing progress note, dated 2-17-06 at 9:45am, which revealed patient #1 was transported to a medical hospital via EMS, where she was pronounced dead at 9:31am. Further review of patient #1's medical record revealed a nursing progress note, dated 2-17-06	A 204		3/22/06

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at 3:00pm (late entry for 9:00am), which stated "Entered room @ approx (approximately) 8:45 (after) HCT (healthcare technician) unable to obtain VS. Pt. unresponsive. Color good - no cyanosis. Unable to obtain BP or apical pulse. (Name of Nurse Manager and Nurse Practitioner) notified immediately. Code blue called @8:50A".

Further review of patient #1's medical record revealed a late entry progress note from the nurse practitioner, dated 2-17-06 at 1510 (3:10pm). The note stated "Asked to evaluate pt in restraint room @ approx 0850 due to having difficulty obtaining pt's BP - After attempting to ck (check) BP x 1 (which was unobtainable) pt was found to be absent of apical pulse and resp. Code Blue Called and CPR initiated...CPR in progress while transported to (name of medical hospital)".

On 3-7-06 the hospital document, "A Framework for a Root Cause Analysis and Action Plan In Response to a Sentinel Event" was reviewed. The document revealed a Code Blue was called on 2-17-06 at 8:50am after staff discovered patient #1 was "absent of a pulse, blood pressure, and respirations". The document indicated patient #1 was in 4-point restraints when the Code Blue was called. Further review of the document revealed patient #1's only identified medical problem was obesity and "There was no evidence of medical instability at the time of admission to Cherry Hospital".

On 3-7-06 the hospital's policy entitled "Isolation Time Out/Seclusion, Restraint/Psychiatric Care" was reviewed. The policy stated "G. During Isolation Time Out, Seclusion, or Restraint 1. Nursing Staff Interventions a. Monitor the patient

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through constant in-person observation and document on the Restrictive Interventions Progress Note Form".

Additionally, under "G. During Isolation Time Out, Seclusion, or Restraint", the policy revealed "1. Nursing Staff Interventions a. 1) Monitor for the following every 15 minutes:
a) Signs of injury.
b) Nutrition/hydration.
c) Vital signs and circulation.
d) Hygiene and elimination
e) Physical status (e.g., breathing) and psychological status (e.g., increased agitation) and comfort.
f) Meeting the criteria for release.
g) If the patient in restraints struggles against the restraints or is hyperactive, observe the patient for early signs of exhaustion (e.g. change in level of consciousness, increased pulse or breathing, sweating, etc."

Review of patient #1's medical record revealed a nursing progress note, dated 2-17-06 (time illegible), which indicated patient #1 had been "loud, intrusive, cheering, chanting, cursing, threatening - refusing to comply (with) ward". The progress note further revealed staff was "unable to effectively redirect" patient #1 and medications, Haldol 7.5mg and Benadryl 50mg IM (intramuscular), were given per physician's order at 5:10am. According to the nursing note patient #1's behavior "continued to escalate" and she "attempted to choke staff member". The note revealed patient #1 was "Placed in NCI hold and then 4 pt (point) restraints at 5:45am. Restraints applied correctly".

Another nursing progress note, dated 2-17-06

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(time illegible), stated patient #1 was "Very out of control and out of restraint. Pt (patient) refused po (oral) meds (medications) and was given Haldol 10mg, Ativan 2mg, and Benadryl 50mg IM @ 7:35A (am). Placed back in restraints @ 7:40A. VS (vital signs) P(pulse) - 74, R(respirations) - 18, BP (Blood Pressure) - 138/76 @ 7:40A". There was no documentation in the progress note regarding how and when patient #1 got out of restraints.

Further review of the medical record revealed the document "Intramuscular Injections (IM) of Psychotropic Medications for Behavioral Emergencies", dated 2-17-06. The physician section, signed and dated by the physician on 2-17-06 at 7:45am, revealed "Combative, Got out of restraints, hit and spit on several techs (healthcare technicians) and nurses". The document revealed no evidence regarding how and when patient #1 got out of restraints.

Further review of the medical record revealed the Restrictive Intervention for Behavior Record, dated 2-17-06, which indicated patient #1 was placed in 4-point restraints from 5:45am - 8:50am, at which time a code blue was called. The document revealed the following information regarding patient #1's restraint episode on 2-17-06:

5:45am - "Attempted to choke staff member in office doorway. Loud threatening and assaultive".
6:00am - "Shaking bed. Pulling at restraints. Refuses to speak to staff".
6:15am - "Pulling restraints threatening staff, yelling, cursing...".
6:30am - "Setting up in bed, cursing staff, yelling...".

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6:45am - "Loud, cursing, threatening, unable to contract for safety".
7:00am - "Continue restraints".
7:00am - "loud, cursing, threatening staff...".
7:15am - "loud, yelling...".
7:30am - "loud, yelling, cursing @ staff. Shaking bed".
7:45am - "Pt. Laying in bed, Quiet @ this time. V/S (vital signs) being taking by nurse".
8:00am - "Pt has been Quiet, Resting in bed".
8:15am - "Pt. Quiet. Just laying in bed".
8:30am - "Pt. still lying in bed, no move".
8:50am - "Code Blue call, Med. Emergency".

The Restrictive Intervention for Behavior Record revealed no documentation that patient #1 had gotten out of restraints at any point from 5:45am - 8:50am.

On the Restrictive Intervention for Behavior Record, dated 2-17-06, staff documented patient #1 refused food/fluid at 6:45am, 7:45am, 8:15am. According to the document, patient #1 refused toileting at 7:15am, 7:45am, and 8:15am. Additionally staff documented "N/A" (not applicable) for ROM (range of motion) at 6:15am, 6:30am, 7:00am, 7:15am, and 7:30am. There was no evidence on the Restrictive Intervention for Behavior Record that staff monitored the required components of patient #1's condition every 15 minutes as outlined in the hospital's policy "Isolation Time Out/Seclusion, Restraint/Psychiatric Care" (signs of injury, nutrition/hydration, vital signs and circulation, hygiene and elimination, physical and psychological status, meeting the criteria for release, and early signs of exhaustion).

According to patient #1's medical record, the last

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	344003	A. BUILDING _____ B. WING _____	C 03/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HOSPITAL	201 STEVENS MILL ROAD GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 204	Continued From page 26	A 204		

set of documented vital signs was at 7:40am (nursing progress note, dated 2-17-06 - time illegible, which was 1 hour and 10 minutes before the Code Blue was called.

Review of the hospital document, "A Framework for a Root Cause Analysis and Action Plan In Response to a Sentinel Event" revealed "Between 7:15a.m.-7:30a.m., the patient (patient #1) got out of restraints and left the restraint room, reaching the area outside the 2 West restraint room. Staff members responded...". The document further revealed there was no documentation in the medical record regarding how patient #1 was able to get out of restraints. The document stated "Policy requires 1:1 monitoring by staff when a patient is in restraints. The patient (patient #1) was able to get out of restraints and leave the restraint room before staff intervened".

Further review of "A Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event" revealed "The last verifiable documentation in the medical record in which it is known that the patient (patient #1) definitely had vital signs was 7:40 a.m. on 2-17-06". According to the document, no further attempts were made to obtain patient #1's vital signs until approximately 8:35am.

On 3-8-06 administrative staff confirmed nursing staff did not monitor patient #1 in accordance with hospital policy.

2. Based on medical record review, review of hospital documents, staff interviews, and review of hospital policy and procedure, nursing staff failed to ensure documentation of patient monitoring at least hourly to determine the need

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A 204	Continued From page 27 for continued restraint as outlined in hospital policy for 1 of 1 sampled patient (patient #1) restrained for behavior management. Review of the policy, "Isolation Time Out/Seclusion, Restraint/Psychiatric Care", revealed "G. During Isolation Time Out, Seclusion, or Restraint 2. Registered Nurse Interventions: b. Evaluate at least every hour to determine the continued need for ITO (isolation time out), seclusion, or restraint and document assessments on Restrictive Procedures Progress Note Form". Review of patient #1's medical record revealed no evidence nursing staff evaluated patient #1 at least hourly as outlined in the hospital's policy "Isolation Time Out/Seclusion, Restraint/Psychiatric Care". Review of the hospital document, "A Framework for a Root Cause Analysis and Action Plan In Response to a Sentinel Event" revealed "There was also failure of the RN to conduct an hourly assessment of the patient while in restraints" and "Hourly RN assessments were not documented as required". On 3-8-06 interview with administrative staff confirmed nursing staff did not conduct hourly assessments of patient #1 while she was in 4-point restraints in accordance with hospital policy. 3. Based on medical record review, review of hospital documents, staff interviews, and review of hospital policy and procedure, nursing staff failed to ensure monitoring of a patient's vital signs 30 minutes after intramuscular (IM)	A 204		

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administration of psychotropic mediations for 1 of 1 sampled patient (patient #1) restrained for behavior management.

On 3-8-06 the hospital policy and procedure entitled "Medication Administration" was reviewed. The policy revealed "18. Blood pressures and pulses shall be taken and recorded prior to and 30 minutes after an injectable anti-psychotic or injectable anti-anxiety agent. Inability to obtain a blood pressure and/or pulse must be documented".

Medical record review revealed a nursing progress note, dated 2-17-06 (time illegible), which stated patient #1 was "Very out of control and out of restraint. Pt (patient) refused po (oral) meds (medications) and was given Haldol 10mg, Ativan 2mg, and Benadryl 50mg IM @ 7:35A (am). Placed back in restraints @ 7:40A. VS (vital signs) P(pulse) - 74, R(respirations) - 18, BP (Blood Pressure) - 138/76 @ 7:40A". There was no documentation of patient #1's vital signs 30 minutes after she received IM psychotropic medications at 7:35am.

Further review of patient #1's medical record revealed the document "Intramuscular Injections (IM) of Psychotropic Medications for Behavioral Emergencies, dated 2-17-06. Under the nursing section, "II. After injection is administered", item #3 (vital signs) was left blank.

Review of the hospital document, "A Framework for a Root Cause Analysis and Action Plan In Response to a Sentinel Event" revealed "There was no documentation of vital signs 30 minutes post injection".

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A 204	Continued From page 29 On 3-8-06 interview with administrative staff confirmed nursing staff did not monitor patient #1's vital signs 30 minutes after receiving IM psychotropic medications on 2-17-06 at 7:35am.	A 204		